2002

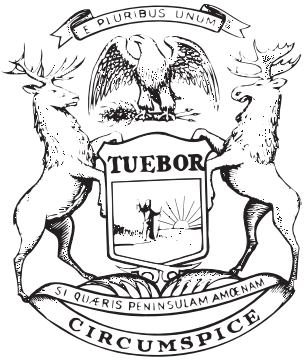
HEALTH INSURERS *including*

Health Maintenance Organizations

Alternative Financing and Delivery Systems

Nonprofit Health Care Corporations

Dental Service Corporations



Forms & Instructions

for required filings
in Michigan

Michigan Department of Consumer & Industry Services

CIS

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FIS-PUB 0091 (11/01)

Department of Consumer & Industry Services
Office of Financial & Insurance Services
Office of Financial Evaluation

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STATE OF MICHIGAN
DEPARTMENT OF CONSUMER AND INDUSTRY SERVICES
OFFICE OF FINANCIAL AND INSURANCE SERVICES

Before the Commissioner of Financial and Insurance Services

In the matter of financial statements and accounting practices and procedures.
_____/ **Order No. 02-055-M**

Issued and entered
this 16th day of December 2002
by Frank M. Fitzgerald
Commissioner

ORDER PRESCRIBING FORMS, CONTENTS, AND INSTRUCTIONS

I
BACKGROUND

Pursuant to Section 438 of the Michigan Insurance Code of 1956, as amended (the Code), MCLA 500.438, MSA 24.1438, the Administrative Procedures Act of 1969, as amended, MCLA 24.201 *et. seq.*, Section 602 of Public Act 350 of 1980, MCLA 550.1602, MSA 24.660 (602), and Section 10 of Public Act 125 of 1963, MCLA 550.360; MSA 24.650(10), the Commissioner is authorized to prescribe forms, contents, and instructions for the completion of annual and quarterly statements of financial condition.

The National Association of Insurance Commissioners (NAIC) has established instructions for the completion of the 2002 annual and the 2003 quarterly statements and forms. These instructions pertain to health entities such as Health Maintenance Organizations (HMOs), Alternative Financing and Delivery Systems (AFDS), Nonprofit Health Care Corporations, and Dental Service Corporations. By completing the financial statements and forms in accordance with their instructions, these entities will submit useful and necessary regulatory information to the Commissioner. These entities shall follow the 2002 NAIC Annual Statement Instructions to the extent that the accounting practices, procedures, and reporting standards are not modified by the Michigan Insurance Code or the 2002 *Forms and Instructions for Required Filings in Michigan*.

The NAIC went through an extensive process to codify all accounting practices and procedures to better standardize the financial reporting of insurers. As such, the NAIC Accounting Practices and Procedures Manual effective January 1, 2001 (Codification) included significant changes from the previous manuals. It is the intent of the NAIC to publish a new Accounting Practices and Procedures Manual annually. The latest version of the manual is as of March 2002. **The manual requires insurers to fully disclose and quantify any deviations from the practices and procedures adopted in the manual. Starting with the first quarter of 2003, insurers must prepare their financial statements in accordance with this new guidance except as modified by this order. This change in accounting principles may have a significant financial impact to some entities. Therefore, the Commissioner is providing a transition period (a prescribed practice) for certain statements of statutory accounting principles (SSAPs) found in the NAIC Accounting Practices and Procedures Manual. The following outlines the transition of the specific SSAPs. There is a full adoption and application as of January 1, 2003 of any SSAP not listed below.**

- **<u>SSAP 16</u> - Electronic Data Processing Equipment and Software**

This SSAP will be adopted using the following transition scenario, whereby the aggregate amount of admitted EDP equipment and operating system software (net of depreciation) shall be limited to the following percentage of the reporting entity's capital and surplus:

Effective January 1, 2003	**25%**
Effective January 1, 2004	**15%**
Effective January 1, 2005	**5%**

Effective January 1, 2006, the requirements of SSAP 16 will be fully adopted.

- **SSAP 19 - Furniture and Equipment; Leasehold Improvements Paid by the Reporting Entity as Lessee; Depreciation of Property and Amortization of Leasehold Improvements**

This SSAP will be adopted using the following transition scenario, whereby the reporting entity will be permitted to report as an admitted asset the following percentage of its book value of furniture and equipment and leasehold improvements:

Effective January 1, 2003	**85%**
Effective January 1, 2004	**55%**
Effective January 1, 2005	**25%**

Effective January 1, 2006, the requirements of SSAP 19 will be fully adopted.

- **SSAP 84 - Certain Health Care Receivables and Receivables Under Government Insured Plans**

Loans or advances to hospitals or other providers are not permitted.

SSAP 84 provided a transition provision in the pharmaceutical rebates and risk sharing receivables when this accounting principle was adopted by the NAIC. SSAP 84 assumed states would adopt codification effective 2001 and therefore, NAIC transitions no longer apply effective January 1, 2003. OFIS will extend these transitions another year. For pharmaceutical and risk sharing receivables, the transition will expire on invoices prior to January 1, 2004. Entities are expected to renegotiate their contracts with pharmacy benefit managers and providers to comply with the requirements of SSAP 84 for future reporting periods.

II
FINDINGS OF FACT AND CONCLUSIONS OF LAW

Based on the foregoing considerations, the Commissioner FINDS and CONCLUDES that:

1. The 2002 NAIC annual statement blank, the 2003 quarterly statement blanks, the 2002 NAIC Annual Statement Instructions, the 2003 NAIC Annual Statement Instructions, the NAIC Accounting Practices and Procedures Manual (effective as of 2000 for the 2002 annual statement filing), the NAIC Accounting Practices and Procedures Manual as of March 2002, including appendices A – F and excluding Actuarial Guideline XXXV in Appendix C (for the 2003 quarterly statement filings), and the 2002 *Forms and Instructions for Required Filings in Michigan* establish appropriate forms and provide filing instructions for HMOs, AFDS, Nonprofit Health Care Corporations, and Dental Service Corporations for filing annual and quarterly statements of financial condition. Nonprofit Health Care Corporations must complete the annual and quarterly statements in accordance with Generally Accepted Accounting Principles (GAAP) as required by Section 550.1205(1) of the Michigan Insurance Code.

2. A copy of the 2002 *Forms and Instructions for Required Filings in Michigan* shall be posted on the web site of the Office of Financial and Insurance Services and shall only be sent provided the entity specifically requests to receive a hard copy by mail.

3. Submission of this information in no way limits the Commissioner from requesting further information regarding the financial condition of a regulated entity. The Commissioner may address inquiries to any

regulated entity concerning the conduct of its business or its financial condition; any regulated entity so addressed shall promptly reply in writing to the Commissioner's inquiries.

4. Failure to comply with all filing instructions and requirements will result in rejection of the materials submitted as not constituting a proper filing and will subject the filing entity to a civil penalty of not less than $1,000 or more than $5,000 and an additional $50 for each day that such company fails to file its information in accordance with Section 438(5) of the Code, MCLA 500.438(5); MSA 24.1438(5).

III
ORDER

Therefore, it is ORDERED that:

1. The 2002 NAIC annual statement blank, the 2003 quarterly statement blanks, the 2002 *Forms and Instructions for Required Filings in Michigan*, the 2002 NAIC Annual Statement Instructions, the 2003 NAIC Annual Statement Instructions, the NAIC Accounting Practices and Procedures Manual (effective as of 2000 for the 2002 annual statement filing), and the NAIC Accounting Practices and Procedures Manual as of March 2002, including appendices A – F and excluding Actuarial Guideline XXXV in Appendix C (for the 2003 quarterly statement filings) are hereby adopted. All companies shall file the NAIC annual and quarterly statements and shall follow the 2002 NAIC Annual Statement Instructions (annual statement filing), the 2003 NAIC Annual Statement Instructions (2003 quarterly statement filings), and the accounting practices, procedures, and reporting standards promulgated by the NAIC, to the extent that the accounting practices, procedures, and reporting standards are not modified by the Michigan Insurance Code or the 2002 *Forms and Instructions for Required Filings in Michigan*.

2. The Office of Financial and Insurance Services (OFIS) shall post a copy of the 2002 *Forms and Instructions for Required Filings in Michigan* on its web site. A hard copy shall only be sent to entities that specifically request a copy.

The Commissioner specifically retains jurisdiction of the matters contained herein and the authority to issue such further order or orders as he shall deem just, necessary, and appropriate.

This Order supercedes Order 01-086-M.

Frank M. Fitzgerald
Commissioner

SIGNIFICANT CHANGES AND REMINDERS FOR THE 2002 FORMS & INSTRUCTIONS

Please review the following for a summary of some of the significant changes and reminders for the 2002 *Forms and Instructions for Required Filings in Michigan*.

1. OFIS has implemented codification for HMOs, AFDS, and Dental Service Corporations effective January 1, 2003, **except as modified by the Commissioner's Order, which is located at the beginning of these instructions.** These companies shall follow the statements of statutory accounting principles as prescribed in the NAIC Accounting Practices and Procedures Manual as of March 2002 (or most current version), including appendices A – F and excluding Actuarial Guideline XXXV in Appendix C when filing financial statements. Nonprofit Health Care Corporations shall follow Generally Accepted Accounting Principles (GAAP) as required by Section 550.1205(1) of the Michigan Insurance Code.

2. The Supplemental Compensation Exhibit is an NAIC supplement that is a required filing for all companies filing under these instructions. Companies are expected to properly complete and file the Supplemental Compensation Exhibit on a timely basis to avoid fines. The Supplemental Compensation Exhibit must be completed even if a company utilizes a management agreement for all or substantially all operations. The amounts reported should include compensation paid to each individual under the management agreement as if the individual were employed by the company.

3. Claims adjustment expenses are all expenses incurred in connection with the recording, adjustment and settlement of claims. Companies are required to report these expenses on the appropriate line of the Statement of Revenue and Expenses in accordance with the NAIC Annual Statement Instructions.

4. All amendments to the financial statements must be signed by appropriate officers and also filed with the NAIC.

GENERAL INFORMATION AND INSTRUCTIONS

ATTENTION ALL COMPANIES

PLEASE SEE THAT THIS NOTICE IS GIVEN TO THE INDIVIDUAL RESPONSIBLE FOR COMPLETING THE ANNUAL STATEMENT.

Information in this booklet is also available on the Internet at www.michigan.gov/ofis/.

This document contains Annual and Quarterly Statement filing instructions and supplemental forms for all Health Maintenance Organizations (HMOs), Alternative Financing and Delivery Systems (AFDS), Nonprofit Health Care Corporations and Dental Service Corporations authorized or eligible to transact business within the State of Michigan. Please read these instructions as well as the Checklist Instructions BEFORE submitting a filing.

Also review the Annual Statement Instructions prepared by the NAIC in order to familiarize yourself with any changes or new reporting requirements. For most companies the NAIC instructions are produced in a loose-leaf binder, with update services offered annually, and are available *only through the NAIC office.* Please contact the NAIC Publications Department at (816) 783-8300 to order instructions. Questions should be directed to the NAIC at (816) 842-3600. The NAIC's address is:

NAIC
2301 McGee Street, Suite 800
Kansas City, Missouri 64108-2604

Unless otherwise stated, follow the NAIC instructions for completing annual and quarterly statements. Supplemental schedules, exhibits and forms not included in the NAIC "Association Edition" are considered part of the annual statement filing for the purpose of complying with Section 438 of the Michigan Insurance Code of 1956, as amended (HMOs and AFDS), Public Act 350 of 1980 (Nonprofit Health Care Corporations), and Public Act 125 of 1963 (Dental Service Corporations).

GENERAL INSTRUCTIONS FOR ANNUAL AND QUARTERLY FINANCIAL STATEMENTS

NAIC Address

Unless otherwise directed, all HMOs, AFDS, Nonprofit Health Care Corporations and Dental Service Corporations are required to file both hard copy and electronic (diskette or internet) annual and quarterly statements with the NAIC. Detailed information and instructions for filing the 2002 annual and the 2003 quarterly statements are available from the NAIC's web site at http://www.naic.org/fast/. Use the following address when submitting annual statements to the NAIC:

Financial Systems & Services
NAIC Financial Database
2301 McGee Street, Suite 800
Kansas City, Missouri 64108-2604

Print Size

All companies are to follow the NAIC instructions for print and statement size requirements for the filing of the 2002 annual statement. Any filing considered unreadable will result in rejection of the material submitted as not constituting an annual statement filing and will subject the filing entity to civil penalties as described in:

Section 438(5) of the Michigan Insurance Code for HMOs and AFDS
Section 550.1811 of the Michigan Insurance Code for Nonprofit Health Care Corporations
Section 550.360 of the Michigan Insurance Code for Dental Service Corporations

Due Dates
All financial statements, supplemental schedules, exhibits and forms should be filed to allow for receipt of the documents no later than the due date set forth in the accompanying checklist(s). If the due date falls on a weekend or holiday, the next business day will be the due date.

Electronic Filing
Companies should not file annual and quarterly diskettes with OFIS. Companies must file electronically with the NAIC.

Companies are encouraged to file their annual and quarterly statements with the NAIC through the Internet. Internet filing will eliminate the need to file on diskette with the NAIC. In order to file on the Internet you must register with the NAIC. You may register on-line at the NAIC Web site at www.naic.org or call the NAIC Financial Systems and Support Department at (816) 783-8600 for additional information.

Toll Free Telephone Number
Companies may contact OFIS toll-free at (877) 999-6442. If an insurer has a toll-free telephone number please provide it on page 1 of the annual and quarterly statements.

Supplemental Checklist on Where to File Certain Documents Within OFIS
See Appendix II for a checklist on where to direct certain required filings within OFIS. The checklist includes filings noted in these instructions, as well as filings required throughout the year as changes or transactions necessitate.

Actuarial Opinion
An actuarial opinion is a required filing for all HMOs, AFDS, Nonprofit Health Care Corporations and Dental Service Corporations. This filing is due by March 1, 2003.

Audited Financial Reports
An audited financial report is a required filing for all HMOs, AFDS, Nonprofit Health Care Corporations and Dental Service Corporations. The audited financial report is a required filing for all HMOs and AFDS regardless of the premium volume limitations specified under Section 1003 of the Michigan Insurance Code. The audited financial report for HMOs and AFDS must be on a statutory basis as required in Chapter 10 of the Michigan Insurance Code. This filing is due by June 1, 2003 for HMOs and AFDS, and due May 1, 2003 for Nonprofit Health Care Corporations and Dental Service Corporations.

Management's Discussion and Analysis
A Management's Discussion and Analysis (MD&A) is a required filing for all HMOs, AFDS, Nonprofit Health Care Corporations and Dental Service Corporations. This filing is due by April 1, 2003. Companies are expected to spend the appropriate amount of time and effort to make this a useful document. Material fluctuations and trends should be fully discussed in this document.

Supplemental Compensation Exhibit
The Supplemental Compensation Exhibit is an NAIC supplement that is a required filing for all companies filing under these instructions. Companies are expected to properly complete and file the Supplemental Compensation Exhibit on a timely basis to avoid fines. The Supplemental Compensation Exhibit must be completed even if a company utilizes a management agreement for all or substantially all operations. The amounts reported should include compensation paid to each individual under the management agreement as if the individual were employed by the company

Electronic Data Processing (EDP) Equipment
Reporting for the 2002 annual statement: EDP equipment (hardware) and operating software may be reported as admitted assets in financial statement filings. Operating software is the program or series of programs necessary to run the operating system.

Application software is made up of word processing, spreadsheet and other programs not considered operating software and may not be reported as an admitted asset. Application software may be expensed when purchased or established as a non-admitted asset and written off over a period of years not to exceed the software's expected useful life.

Effective as of January 1, 2003, EDP Equipment shall be reported in accordance with the Accounting Practices and Procedures Manual as of March 2002, except as modified by the Commissioner's Order, which is located at the beginning of these instructions.

HEALTH MAINTENANCE ORGANIZATIONS AND ALTERNATIVE FINANCING AND DELIVERY SYSTEMS SPECIFIC INSTRUCTIONS

Goodwill, prepaid expenses, deferred taxes, premiums over 90 days past due and other intangible assets, must appear as non-admitted assets in the financial statements for reporting in the 2002 annual statement. Effective as of January 1, 2003, these items shall be reported in accordance with the Accounting Practices and Procedures Manual as of March 2002.

Drug carve out or maternity case receivables due from the Department of Community Health should be reported on the health care receivable line of the balance sheet.

Health care receivables due from affiliates should be reported on the Amounts Due from Parent, Subsidiaries and Affiliates line of the balance sheet.

Statutory Deposits should be classified on the balance sheet and supporting schedules in accordance with the underlying assets. The Statutory Deposit should also be reported on Schedule E Part 2 – Special Deposits. HMOs must be in compliance with the statutory deposit requirements found in Section 3553 of the Michigan Insurance Code. AFDS must be in compliance with the statutory deposit guidelines prescribed in Michigan Bulletin 2001-5.

Pharmacy Expenses reported by an HMO should be reported on the Prescription Drugs line of the Statement of Revenue and Expenses. Pharmacy expenses should be reported net of any pharmacy rebates or drug carve out amounts.

Claims adjustment expenses should be reported on the appropriate line of the Statement of Revenue and Expenses in accordance with the NAIC Annual Statement Instructions. Claims adjustment expenses are all expenses incurred in connection with the recording, adjustment and settlement of claims.

Notes to Financial Statement must be completed in accordance with the NAIC Annual Statement Instructions. Photo-copies of the notes from the CPA report will not be accepted.

Copies of the current provider directory, certificates of coverage and member handbook for each line of business (group, non-group, individual, conversion, Medicaid, Medicare etc.) are required filings, and are due by April 15, 2003.

NONPROFIT HEALTH CARE CORPORATIONS SPECIFIC INFORMATION AND INSTRUCTIONS

Nonprofit Health Care Corporations must complete the NAIC annual and quarterly statements in accordance with Generally Accepted Accounting Principles (GAAP) as required by Section 550.1205(1) of the Michigan Insurance Code. Nonprofit Health Care Corporations shall file the NAIC annual statement with OFIS and the NAIC on both a consolidated and a non-consolidated basis. The consolidated NAIC annual statement shall identify its consolidated nature and also disclose all consolidated entities. The NAIC quarterly statement shall be filed on a non-consolidated basis only.

THE OFFICE OF FINANCIAL EVALUATION STRIVES TO MAKE THIS DOCUMENT ACCURATE AND UNDERSTANDABLE. PLEASE LET US KNOW OF ANY ERRORS OR SUGGESTIONS FOR IMPROVEMENT.

GENERAL INSTRUCTIONS

For Companies to Use Checklist

Please Note: **This state's instructions for companies to file with the NAIC are included in this Checklist. The NAIC will send mailing labels and other information to all companies but will not be sending their own checklist.**

Electronic filing is intended to include filing via the Internet or via diskette with the NAIC. Companies that file with the NAIC via the Internet are not required to submit diskettes to the NAIC. Companies are encouraged to file with the NAIC via the Internet.

Column (1) (Checklist)

Companies may use the checklist to submit to a state, if the state requests it. Companies should copy the checklist and place an "x" in this column when mailing information to the state.

Column (2) (Line #)

Line # refers to a standard filing number used for easy reference. This line number may change from year to year.

Column (3) (Required Filings)

Name of item or form to be filed.

PLEASE NOTE: The ***Annual Statement Electronic Filing*** includes the annual statement data and all supplements due March 1, per the *Annual Statement Instructions.* This includes all detail investments schedules and other supplements for which printed detail is exempted per the *Annual Statement Instructions*.

The ***March .PDF Filing*** is the .pdf file for annual statement data, detail for investment schedules, and supplements due March 1.

The ***Risk-Based Capital Electronic Filing*** includes all risk-based capital data.

The ***Supplemental Electronic Filing*** includes all supplements due April 1, per the *Annual Statement Instructions.*

The ***Supplemental .PDF Filing*** is the .pdf file for all supplemental schedules and exhibits due April 1.

The ***Quarterly Electronic Filing*** includes the quarterly statement data.

The ***Quarterly .PDF Filing*** is the .pdf file for the quarterly statement data.

The ***June .PDF Filing*** is the .pdf file for the Audited Financial Statements.

Column (4) (Number of Copies)

Indicates the number of copies that each foreign or domestic company is required to file for each type of form. The 1999 *Annual Statement Instructions* were modified to waive paper filings of certain NAIC supplements (those supplements previously included in the Electronic Filing Pilot Project) and certain investment schedule detail, if such investment schedule data is available to the states via the NAIC database. The checklists have been modified to reflect this action taken by the Blanks (EX4) Task Force. XXX appears in the "Number of Copies" "Foreign" column for the appropriate schedules and exhibits. Some states have chosen to waive printed quarterly and annual statements from their foreign insurers and to rely upon the NAIC database for these filings. This waiver could include supplemental annual statement filings. The XXX in this column might signify that the state has waived the paper filing of the annual statement and all supplements.

Column (5) (Due Date)

Indicates the date on which the company must file the form.

Column (6) (Form Source)

This column contains one of three words: "NAIC," "State," or "Company," If this column contains "NAIC," the company must obtain the forms from the appropriate vendor. If this column contains "State," the state will provide the forms with the filing instructions (generally on its web site). If this column contains "Company," the company, or its representative (e.g., its CPA firm), is expected to provide the form based upon the appropriate state instructions or the NAIC *Annual Statement Instructions.*

Column (7) (Applicable Notes)

This column contains references to the Notes to the Instructions that apply to each item listed on the checklist. The company should carefully read these notes before submitting a filing.

	Notes and Instructions (A-K apply to all filings)	
A	Required Filings Contact Person:	Unless otherwise directed, all communications and inquiries regarding annual statements, quarterly statements, and Michigan supplemental forms should be directed to OFIS - Office of Financial Evaluation at (517) 373-0246.
B	Mailing Address:	Regular Mail: Michigan Department of Consumer and Industry Services Office of Financial and Insurance Services Office of Financial Evaluation Attention: Supervisory Affairs and Insurance Monitoring Division P.O. Box 30220 Lansing, Michigan 48909-7720 Express Mail (UPS, Federal Express, etc.): Michigan Department of Consumer and Industry Services Office of Financial and Insurance Services Office of Financial Evaluation Attention: Supervisory Affairs and Insurance Monitoring Division Ottawa Building – 2nd Floor 611 West Ottawa Street Lansing, Michigan 48933
C	Mailing Address for Filing Fees:	Filing fees are billed under a separate invoice.
D	Mailing Address for Premium Taxes:	**Regular Mail:** Michigan Department of Treasury P.O. Box 30059 Lansing, Michigan 48909 **Express Mail:** Michigan Department of Treasury 7285 Parsons Road Dimondale, Michigan 48821 **DO NOT SEND MICHIGAN SINGLE BUSINESS TAX RETURNS WITH ANNUAL OR QUARTERLY FILINGS.**
E	Delivery Instructions:	All filings must be physically received at one of the addresses in Note B no later than the indicated due date. If the due date falls on a weekend or holiday, then the deadline is extended to the next business day.
F	Late Filings:	Failure to file in accordance with the instructions contained herein and by the indicated due date will immediately subject

		the company to a monetary penalty as described in the General Information and Instructions Section.
G	Original Signatures:	The annual and quarterly statements of all companies must contain original signatures.
H	Signatures / Notarization / Certification:	The annual and quarterly statements of all companies must contain signatures of at least three responsible officers, such as the CEO, CFO, President, Secretary or Treasurer and be properly notarized. If those parties are not available to sign the statement, contact OFIS at least ten (10) business days prior to the statement due date to ascertain whether other arrangements are necessary.
I	Amended Filings:	Amended items must be filed within 10 days of their amendment, along with an explanation of the amendments. If there are signature requirements for the original filing, the same requirements must be followed for any amendment. **In accordance with NAIC Annual Statement Instructions, if a filing is amended, the amendment must also be filed with the NAIC, including an amended electronic version.**
J	Exceptions from Normal Filings:	Companies should apply at least 30 days prior to the due date.
K	Bar Codes:	Forms as identified in the NAIC Annual Statement Filing Instructions are required to have a bar code affixed in the upper right hand corner of the form. Bar code standards can be found in the NAIC instructions. Bar codes for Michigan filings should be generated according to NAIC instructions. The codes are: Form — Document Identifier Summary of Subsidiary Corporations (FIS 0084)……..003 Revenue and Expense Report for HMOs (FIS 0317)……004 HMO Inpatient Discharges & Benefit Payouts Report (FIS 0320)……005 Working Capital Calculation (FIS 0321)……..006 **FILINGS MAY BE REJECTED DUE TO BAR CODE ERRORS. PLEASE VERIFY FOR ACCURACY.**
L	Affidavit of Filing	This state waives foreign insurers from filing printed annual and quarterly statements and supplements. The Affidavit of Filing is not required.
M	NONE Filings:	See NAIC Annual Statement Instructions. Exceptions to these instructions are noted on the form.
N	Electronic Filings with the NAIC	OFIS follows the Annual Statement Instructions related to investment schedule detail and certain supplements. As such, certain items that are captured on the NAIC database are not required to be submitted in hard copy format from foreign insurers. If this information is filed with the domiciliary state and with the NAIC, it is not necessary to file with this state.
O	Filings Discontinued since Last Year:	None.
P	Management's Discussion and Analysis:	Prepared in accordance with the NAIC instructions and submitted with the annual statement.
Q	Statement of Actuarial Opinion:	Prepared in accordance with the NAIC instructions and submitted with the annual statement.
R	Audited Financial Statements – HMOs and AFDS:	**THE ANNUAL AUDITED FINANCIAL REPORT AS REQUIRED BY CHAPTER 10 OF THE MICHIGAN INSURANCE CODE SHALL BE FILED BY ALL HMOs AND AFDS, REGARDLESS OF PREMIUM VOLUME.** The independent audit required by Chapter 10 of the Michigan Insurance Code shall be conducted in accordance with

		Generally Accepted Auditing Standards (GAAS). The audited financial statements shall be on a Statutory Accounting Principles (SAP) basis except where the Commissioner specifies, in the reasonable exercise of his discretion, a different basis for a specific company. **AUDITED FINANCIAL STATEMENTS PRESENTED ON A GENERALLY ACCEPTED ACCOUNTING PRINCIPLES (GAAP) BASIS WITH RECONCILIATION FROM GAAP TO SAP IS NOT ACCEPTABLE.** The audited financial statements must include a copy of the independent public accountant's qualifications letter to the insurer stating the independent public accountant's understanding that the Commissioner will be relying on the audited statements. The accountant's qualifications letter is required under Section 500.1019 of the Michigan Insurance Code. **Independent CPA –** Companies shall follow the provisions of Section 500.1009 of the Michigan Insurance Code regarding the appointment or change in independent CPA. In conjunction with the appointment or change in independent CPA, companies shall file the letter of awareness as required in Section 500.1009(2).
S	Notification of Adverse Financial Condition:	See Michigan Insurance Law 500.1015
T	Report on Significant Deficiencies in Internal Controls:	See Michigan Insurance Law 500.1017
U	Michigan Forms (FIS 0084, 0279, 0317, 0318, 0320, 0321, 0322):	Instructions to these forms are located just before the forms in Appendix I.
V	Audited Financial Statements – Non profit Heath Care Corporations:	Nonprofit Health Care Corporations are required to file a consolidated financial statement prepared by an independent certified public accountant, and a separate audited financial statement for each subsidiary and affiliate included in the consolidated statement with OFIS.
W	Liability Listing – Nonprofit Health Care Corporations:	Nonprofit Health Care Corporations must provide a listing of all new liabilities added to the NAIC annual statement since December 31, 1978. Section 550.1205(1) gives the Commissioner the authority to disapprove the creation of any new liability, which is properly includable in the contingency reserves.
X	Audited Financial Statements – Dental Service Corporations:	Dental Service Corporations independent annual audited financial statements must be presented on a Statutory basis.
Y	Holding Company Registration:	**INSURANCE HOLDING COMPANY ACT FORMS AND INSTRUCTIONS CAN BE FOUND ON THE OFIS WEB SITE AT www.michigan.gov/ofis/** All domestic insurers who are a member of a holding company system and all other insurers subject to registration under Michigan's Holding Company Act must file holding company registration statements, including exhibits, by May 1, 2003. For insurers subject to registration under Section 1324: a) Annual Form B and C registration statements must be filed by May 1. b) The Form B and C statements are to be in accordance with Michigan's Holding Company Act, rules, bulletins and orders.

		c) If there has been no change from the previous year, the statement must be restated rather than indicating "no change." d) Audited financial statements of the registrant's ultimate controlling business entity (e.g., a corporation, trust, or partnership) must be included in the filing. If audited statements are not available by May 1, the rest of the Form B must be filed by May 1, and the statements filed by June 1. e) If a person or persons ultimately controlling the insurer is an individual or group of individuals that do not meet the exemption criteria of Section 1325(3), that person must file, under oath (on the format provided in the Commissioner's Order #94-293M of September 12, 1994) information disclosing the financial position of that individual or group of individuals. f) If an individual is the ultimate controlling person of an insurer, the Form B holding company registration statement is to be signed and certified by that individual. g) The Michigan holding company act provides for substantial penalties for late or incomplete filings. Late or incomplete submissions are also subject to penalties under Section 438(5). h) If during the year there are any material changes to information filed in the annual registration statement, an amendment is due no later than 15 days after the end of the month in which the change occurred.
Z	Current Provider Directory, Certificates of Coverage and Member Handbook	All HMOs and AFDS shall file a copy of the current provider directory, current certificates of coverage and member handbooks for each line of business offered (group, non-group, individual, conversion, Medicaid, Medicare etc.). **These documents shall be filed and are due by April 15, 2003. Please send these filings to the Health Plans Division of the Office of Financial and Insurance Services.**

HEALTH MAINTENANCE ORGANIZATIONS

COMPANY NAME: _____ NAIC Company Code: _____
Contact: _____ Telephone: _____
REQUIRED FILINGS IN THE STATE OF: *MICHIGAN* Filings Made During the Year 2003

(1) Check-list	(2) Line #	(3) REQUIRED FILINGS FOR THE ABOVE STATE	(4) NUMBER OF COPIES*			(5) DUE DATE	(6) FORM SOURCE**	(7) APPLICABLE NOTES
			Domestic		Foreign			
			State	NAIC	State			
		I. NAIC FINANCIAL STATEMENTS						
	1	Annual Statement (8 ½"x14")	1	1	xxx	3/1	NAIC	A-K, M
	1.1	Printed Investment Schedule detail (Pages E01-E25) @	1	1	xxx	3/1	NAIC	A-K, M
	2	Quarterly Financial Statement (8 ½" x 14")	1	1	xxx	5/15, 8/15, 11/15	NAIC	A-K, M
		II. NAIC SUPPLEMENTS						
	10	Statement of Actuarial Opinion	1	1	xxx	3/1	Company	A-K, Q
	11	Investment Risk Interrogatories	1	1	xxx	4/1	NAIC	A-K, M
	12	Long-term Care Experience Reporting Forms	xxx	1	xxx	4/1	NAIC	A-K, M
	13	Management Discussion & Analysis	1	1	xxx	4/1	Company	A-K, P
	14	Medicare Supplement Insurance Experience Exhibit	xxx	1	xxx	3/1	NAIC	A-K, M
	15	Risk-Based Capital Report	1	1	N/A	3/1	NAIC	A-K
	16	Supplemental Compensation Exhibit	1	N/A	N/A	3/1	NAIC	A-K, M
	17	SVO Compliance Certification	xxx	xxx	xxx	3/1, 5/15, 8/15, 11/15	NAIC	A-K
		III. ELECTRONIC FILING REQUIREMENTS						
	30	Annual Statement Electronic Filing	xxx	1	xxx	3/1	NAIC	A-K, M
	31	March .PDF Filing	xxx	1	xxx	3/1	NAIC	A-K, M
	32	Risk-Based Capital Electronic Filing	xxx	1	N/A	3/1	NAIC	A-K, M
	33	Supplemental Electronic Filing	xxx	1	xxx	4/1	NAIC	A-K, M
	34	Supplemental .PDF Filing	xxx	1	xxx	4/1	NAIC	A-K, M
	35	Quarterly Electronic Filing	xxx	1	xxx	5/15, 8/15, 11/15	NAIC	A-K, M
	36	Quarterly .PDF Filing	xxx	1	xxx	5/15, 8/15, 11/15	NAIC	A-K, M
	37	June .PDF Filing	xxx	1	xxx	6/1	NAIC	A-K, M
		IV. AUDITED FINANCIAL STATEMENTS						
	51	Accountants Letter of Qualifications	1	N/A	N/A	6/1	Company	A-K
	52	Audited Financial Statements	1	1	xxx	6/1	Company	A-K, R
	53	Audited Financial Statements Exemption Affidavit	1	N/A	N/A	6/1	Company	A-K
	54	Independent CPA	1	N/A	N/A	6/1	Company	A-K, R
	55	Notification of Adverse Financial Condition	1	N/A	N/A	SEE NOTE	Company	A-K, S
	56	Report of Significant Deficiencies in Internal Controls	1	N/A	N/A	8/1	Company	A-K, T
	57	Request for Exemption to File	1	N/A	N/A	SEE NOTE	Company	A-K
		V. STATE REQUIRED FILINGS						
	101	Filings Checklist (with Column 1 completed)		1			State	
	102	State Filing Fees		0		SEE NOTE	State	C
	103	Affidavit of Filing	0	0	0	SEE NOTE	State	L
	104	Quarterly Notice of Medicaid Claims Defects	1	xxx	1	1/31, 4/30, 7/31, 10/31	State-FIS 0279	A-K, U
	105	Revenue and Expense Reports for HMOs	1	xxx	1	3/1, 5/15, 8/15, 11/15	State-FIS 0317	A-K, U
	106	Complaint and Grievance Summary for Health Carriers	1	xxx	1	4/15	State-FIS 0318	A-K, U
	107	Michigan Health Insurance Enrollment, Premiums and Losses	1	xxx	1	3/1	State-FIS 0322	A-K, U
	108	HMO Inpatient Discharges & Benefit Payouts Report	1	xxx	1	3/1, 5/15, 8/15, 11/15	State-FIS 0320	A-K, U
	109	Insurance Holding Company System Registration Statement – if subject to registration under Michigan Act	1	xxx	xxx	5/1	Company	A-K, Y
	110	Working Capital Calculation	1	xxx	1	3/1, 5/15, 8/15, 11/15	State-FIS 0321	A-K, U
	111	Copy of Current Provider Directory, Current Certificates of Coverage and Current Member Handbook for each line of business	1	xxx	xxx	4/15	Company	A-K, Z

*If XXX appears in this column, this state does not require this filing, if hard copy is filed with the state of domicile and the NAIC and if the data is filed electronically with the NAIC. If N/A appears in this column, the filing is required with the domiciliary state.

**If Form Source is NAIC, the form should be obtained from the appropriate vendor.

@If schedule is included in the annual statement submitted as item #1, an additional copy is not required.

ALTERNATIVE FINANCING AND DELIVERY SYSTEMS

COMPANY NAME: _____ NAIC Company Code: _____
Contact: _____ Telephone: _____
REQUIRED FILINGS IN THE STATE OF: *MICHIGAN* Filings Made During the Year 2003

(1) Check-list	(2) Line #	(3) REQUIRED FILINGS FOR THE ABOVE STATE	(4) NUMBER OF COPIES*			(5) DUE DATE	(6) FORM SOURCE**	(7) APPLICABLE NOTES
			Domestic		Foreign			
			State	NAIC	State			
		I. NAIC FINANCIAL STATEMENTS						
	1	Annual Statement (8 ½"x14")	1	1	xxx	3/1	NAIC	A-K, M
	1.1	Printed Investment Schedule detail (Pages E01-E25) @	1	1	xxx	3/1	NAIC	A-K, M
	2	Quarterly Financial Statement (8 ½" x 14")	1	1	xxx	5/15, 8/15, 11/15	NAIC	A-K, M
		II. NAIC SUPPLEMENTS						
	10	Statement of Actuarial Opinion	1	1	xxx	3/1	Company	A-K, Q
	11	Investment Risk Interrogatories	1	1	xxx	4/1	NAIC	A-K, M
	12	Long-term Care Experience Reporting Forms	xxx	1	xxx	4/1	NAIC	A-K, M
	13	Management Discussion & Analysis	1	1	xxx	4/1	Company	A-K, P
	14	Medicare Supplement Insurance Experience Exhibit	xxx	1	xxx	3/1	NAIC	A-K, M
	15	Risk-Based Capital Report	1	1	N/A	3/1	NAIC	A-K
	16	Supplemental Compensation Exhibit	1	N/A	N/A	3/1	NAIC	A-K, M
	17	SVO Compliance Certification	xxx	xxx	xxx	3/1, 5/15, 8/15, 11/15	NAIC	A-K
		III. ELECTRONIC FILING REQUIREMENTS						
	30	Annual Statement Electronic Filing	xxx	1	xxx	3/1	NAIC	A-K, M
	31	March .PDF Filing	xxx	1	xxx	3/1	NAIC	A-K, M
	32	Risk-Based Capital Electronic Filing	xxx	1	N/A	3/1	NAIC	A-K, M
	33	Supplemental Electronic Filing	xxx	1	xxx	4/1	NAIC	A-K, M
	34	Supplemental .PDF Filing	xxx	1	xxx	4/1	NAIC	A-K, M
	35	Quarterly Electronic Filing	xxx	1	xxx	5/15, 8/15, 11/15	NAIC	A-K, M
	36	Quarterly .PDF Filing	xxx	1	xxx	5/15, 8/15, 11/15	NAIC	A-K, M
	37	June .PDF Filing	xxx	1	xxx	6/1	NAIC	A-K, M
		IV. AUDITED FINANCIAL STATEMENTS						
	51	Accountants Letter of Qualifications	1	N/A	N/A	6/1	Company	A-K
	52	Audited Financial Statements	1	1	xxx	6/1	Company	A-K, R
	53	Audited Financial Statements Exemption Affidavit	1	N/A	N/A	6/1	Company	A-K
	54	Independent CPA	1	N/A	N/A	6/1	Company	A-K, R
	55	Notification of Adverse Financial Condition	1	N/A	N/A	SEE NOTE	Company	A-K, S
	56	Report of Significant Deficiencies in Internal Controls	1	N/A	N/A	8/1	Company	A-K, T
	57	Request for Exemption to File	1	N/A	N/A	SEE NOTE	Company	A-K
		V. STATE REQUIRED FILINGS						
	101	Filings Checklist (with Column 1 completed)		1			State	
	102	State Filing Fees		0		SEE NOTE	State	C
	103	Affidavit of Filing	0	0	0	SEE NOTE	State	L
	104	Insurance Holding Company System Registration Statement – if subject to registration under Michigan Act	1	xxx	xxx	5/1	Company	A-K, Y
	105	Complaint and Grievance Summary for Health Carriers	1	xxx	1	4/15	State-FIS 0318	A-K, U
	106	Working Capital Calculation	1	xxx	1	3/1, 5/15, 8/15, 11/15	State-FIS 0321	A-K, U
	107	Michigan Health Insurance Enrollment, Premiums and Losses	1	xxx	1	3/1	State-FIS 0322	A-K, U
	108	Copy of Current Provider Directory, Current Certificates of Coverage and Current Member Handbook for each line of business	1	xxx	xxx	4/15	Company	A-K, Z

*If XXX appears in this column, this state does not require this filing, if hard copy is filed with the state of domicile and the NAIC and if the data is filed electronically with the NAIC. If N/A appears in this column, the filing is required with the domiciliary state.

**If Form Source is NAIC, the form should be obtained from the appropriate vendor.

@If schedule is included in the annual statement submitted as item #1, an additional copy is not required.

HOSPITAL, MEDICAL, DENTAL, AND INDEMNITY CORPORATIONS

COMPANY NAME: _____ NAIC Company Code: _____
Contact: _____ Telephone: _____
REQUIRED FILINGS IN THE STATE OF: *MICHIGAN* Filings Made During the Year 2003

(1) Check-list	(2) Line #	(3) REQUIRED FILINGS FOR THE ABOVE STATE	(4) NUMBER OF COPIES*			(5) DUE DATE	(6) FORM SOURCE **	(7) APPLICABLE NOTES
			Domestic		Foreign			
			State	NAIC	State			
		I. NAIC FINANCIAL STATEMENTS						
	1	Annual Statement (8 ½"X14")	1	1	xxx	3/1	NAIC	A-K, M
	1.1	Printed Investment Schedule detail (Pages E01-E25) @	1	1	xxx	3/1	NAIC	A-K, M
	2	Quarterly Financial Statement (8 ½" x 14")	1	1	xxx	5/15, 8/15, 11/15	NAIC	A-K, M
		II. NAIC SUPPLEMENTS						
	10	Statement of Actuarial Opinion	1	1	xxx	3/1	Company	A-K, Q
	11	Investment Risk Interrogatories	1	1	xxx	4/1	NAIC	A-K, M
	12	Long-term Care Experience Reporting Forms	xxx	1	xxx	4/1	NAIC	A-K, M
	13	Management Discussion & Analysis	1	1	xxx	4/1	Company	A-K, P
	14	Medicare Supplement Insurance Experience Exhibit	xxx	1	xxx	3/1	NAIC	A-K, M
	15	Risk-Based Capital Report	1	1	N/A	3/1	NAIC	A-K
	16	Supplemental Compensation Exhibit	1	N/A	N/A	3/1	NAIC	A-K, M
	17	SVO Compliance Certification	xxx	xxx	xxx	3/1, 5/15, 8/15, 11/15	NAIC	A-K
		III. ELECTRONIC FILING REQUIREMENTS						
	30	Annual Statement Electronic Filing	xxx	1	xxx	3/1	NAIC	A-K, M
	31	March .PDF Filing	xxx	1	xxx	3/1	NAIC	A-K, M
	32	Risk-Based Capital Electronic Filing	xxx	1	N/A	3/1	NAIC	A-K, M
	33	Supplemental Electronic Filing	xxx	1	xxx	4/1	NAIC	A-K, M
	34	Supplemental .PDF Filing	xxx	1	xxx	4/1	NAIC	A-K, M
	35	Quarterly Electronic Filing	xxx	1	xxx	5/15, 8/15, 11/15	NAIC	A-K, M
	36	Quarterly .PDF Filing	xxx	1	xxx	5/15, 8/15, 11/15	NAIC	A-K, M
	37	June .PDF Filing	xxx	1	xxx	6/1	NAIC	A-K, M
		IV. AUDITED FINANCIAL STATEMENTS						
	51	Accountants Letter of Qualifications	1	N/A	N/A	5/1	Company	A-K
	52	Audited Financial Statements	1	1	xxx	5/1	Company	A-K, V or X
	53	Audited Financial Statements Exemption Affidavit	1	N/A	N/A	5/1	Company	A-K
	54	Independent CPA	1	N/A	N/A	5/1	Company	A-K, R
	55	Notification of Adverse Financial Condition	1	N/A	N/A	SEE NOTE	Company	A-K, S
	56	Report of Significant Deficiencies in Internal Controls	1	N/A	N/A	8/1	Company	A-K, T
	57	Request for Exemption to File	1	N/A	N/A	SEE NOTE	Company	A-K
		V. STATE REQUIRED FILINGS						
	101	Filings Checklist (with Column 1 completed)		1			State	
	102	State Filing Fees		0		SEE NOTE	State	C
	103	Affidavit of Filing	0	0	0	SEE NOTE	State	L
	104	Summary of Subsidiary Corporations	1	xxx	1	3/1	State-FIS 0084	A-K, U
	105	Complaint and Grievance Summary for Health Carriers	1	xxx	1	4/15	State-FIS 0318	A-K, U
	106	Working Capital Calculation	1	xxx	1	3/1, 5/15, 8/15, 11/15	State-FIS 0321	A-K, U
	107	Michigan Health Insurance Enrollment, Premiums and Losses	1	xxx	1	3/1	State-FIS 0322	A-K, U
	108	Listing of all liabilities added to the NAIC Annual Statement since December 31, 1978 (BCBSM Only)	1	xxx	xxx	3/1	Company	A-K, W

*If XXX appears in this column, this state does not require this filing, if hard copy is filed with the state of domicile and the NAIC and if the data is filed electronically with the NAIC. If N/A appears in this column, the filing is required with the domiciliary state.
**If Form Source is NAIC, the form should be obtained from the appropriate vendor.
@If schedule is included in the annual statement submitted as item #1, an additional copy is not required.

APPENDIX I:

FORMS AND INSTRUCTIONS

FORM INSTRUCTIONS

FIS 0084 Summary of Subsidiary Corporations
FIS 0279 Quarterly Notice of Medicaid Claims Defects
FIS 0317 Revenue and Expense Report for HMOs
FIS 0318 Complaint and Grievance Summary for Health Carriers
FIS 0320 HMO Inpatient Discharges & Benefit Payouts Report
FIS 0321 Working Capital Calculation
FIS 0322 Michigan Health Insurance Enrollment, Premiums and Losses

Review the checklist to determine which form is appropriate for each type of entity. Forms FIS 0279, FIS 0317 and FIS 0320 apply to HMOs. Form FIS 0321 applies to HMOs, AFDS and Nonprofit Dental Care Corporations. Form FIS 0318 applies to all health carriers (HMOs, AFDS, BCBSM). Form FIS 0322 applies to all entities filing under these instructions.

Instructions for Forms FIS 0084, FIS 0279, FIS 0318, FIS 0321 and FIS 0322 are included on those forms. Instructions for Forms FIS 0317 and FIS 0320 are detailed below.

Return completed forms to OFIS on or before the due date indicated in the required filing checklist.

DO NOT USE LAST YEAR'S FORMS. Blank forms follow these instructions.

If you have questions about completion of the above forms, contact the Office of Financial Evaluation at (517) 373-0246.

REVENUE AND EXPENSE REPORT FOR HMOs (FIS 0317)

The purpose of the Revenue and Expense Report for HMOs is to separate premium and expense information by type of business in order to better analyze operating results and aid in the regulatory process.

Information in this report is patterned after the NAIC annual and quarterly statement: Statement of Revenue and Expenses. Companies should utilize NAIC annual statement instructions for classifying revenues and expenses to each line in the report. The totals reported in this report should match the amounts reported in the Statement of Revenue and Expenses.

Each line in this report must be broken down by type of business and reported in the appropriate column. Instructions detailing the proper columnar classification is detailed below.

Member Months – Line 1
Report member months for employer and association group, non-group and group conversion members, and other than Medicare Risk members in column 1, MI – Child member in column 2, Medicare Risk members in column 3 and Medicaid members in column 4.

Net Premium Income – Line 2
Premium reported in line 1 that is received from:

a. Employer and association groups, non-group enrollees and group conversion enrollees should be reported in column 1.
b. MI - Child program should be reported in column 2.
c. Enrollees or their group sponsor for Medicare risk coverage should be reported in column 3.

Fee-for-service – Line 4
Revenue received from fee-for-service should be reported in column 5.

Risk Revenue - Line 5
Revenue received from the Federal Government relating to Title XVII Medicare for enrollees in Medicare risk contracts should be reported in line 5 column 3.

All other Medicare Risk (enrollee premium) revenue received from Medicare risk contract enrollees or their employers, in the case of retiree groups, should be reported in line 2 column 3.
Revenue received from the Michigan Department of Community Health relating to Title XIX Medicaid for Medicaid enrollees, include add-ons for transportation and EPSDT, etc., if any, should be reported in column 4.

Write-in Health Care Revenues – Line 6
Write-in for other health care related revenues reported in line 6 should be reported in the column applicable to the actual income. If revenue from this line cannot be assigned to specific columns, the company must allocate the income between all columns using a basis that can be supported by the company.

Medical and Hospital – Lines 9 through 18
Medical and Hospital expenses reported in lines 9 through 18 should be reported in the column applicable to the actual expense. Please report pharmacy expenses on Line 12 – Prescription Drugs. Pharmacy expenses should be reported on this line net of any pharmacy rebates or drug carve out amounts.

Claims and Administration Expenses – Lines 20 and 21
Claims Adjustment Expenses and General Administrative Expenses should be reported in the column applicable to the actual expense. If expenses from these lines cannot be assigned to specific columns, the company must allocate the expenses between all columns using a basis that can be supported by the company.

Investment and Write-in for Other Income – Lines 25, 26 and 29
Investment income reported in line 25, net realized capital gains or losses reported in line 26 and write-in for other income reported in line 29 should be reported in the column applicable to the actual income. If income from these lines cannot be assigned to specific columns, the company must allocate the income between all columns using a basis that can be supported by the company.

Write-in for Other Expenses and Income Taxes – Lines 29 and 31
Write-in for Other Expenses and Federal Income Taxes should be reported in the column applicable to the actual expense. If expenses from these lines cannot be assigned to specific columns, the company must allocate the expenses between all columns using a basis that can be supported by the company.

HMO INPATIENT DISCHARGES AND BENEFIT PAYOUTS REPORT (FIS 0320)

Section 1, Name(s) of Contracted Hospitals: List the contracted hospitals where the company's members were discharged from during the reporting period.

Section 2, Name(s) of Non-Contracted Hospitals: List the non-contracted hospitals where the company's members were discharged from during the reporting period.

Section 1 & 2, Discharges: Report the number of members who are discharged from an overnight medical care facility (usually a hospital, but can include an extended care facility) during the reporting period. If discharges are not included on one reporting period's report because of the timing when the data is received, the company should include these discharges on the next reporting period's report. In sections 1 and 2, the company must breakdown the discharges from contracted and non-contracted hospitals between elective and emergency services. Emergency discharges should include any health services that are medically necessary services provided for the onset of a medical condition that manifests itself by signs and symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the enrollee's health or to a pregnancy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. For clarification, pregnancies with a normal delivery (no complications) should be reported as an elective discharge on this report. All other type health services should be classified as elective unless otherwise approved or directed by OFIS.

Section 3, Discharge Statistics: Report the total number of elective discharges from contracted and non-contracted hospitals and compute the percentage. If the company has more than 10% elective discharges from non-contract hospitals, the company may be required to establish a hospital reserve fund equal to 3 months'

projected claims from such hospitals in accordance with Section 3529(5) of the Michigan Insurance Code. Section 3 also requires companies to report an estimated amount for this hospital reserve fund, which should be the estimated amount of 3 months' projected incurred (payments plus reserves) claims from non-contract hospitals. Only companies that have more than 10% elective discharges from non-contract hospitals must report this amount.

Section 4, Total Benefit Payouts: The company must report all medical and hospital expenses paid to providers. The total medical and hospital expenses reported in section 4 must tie to the Underwriting and Investment Exhibit, Analysis of Claims Unpaid-Prior Year-Net of Reinsurance, total of columns 1 and 2 of the company's filed financial statements. The company must report the amount and percentage of all medical and hospital expenses between those paid to contracted and non-contracted providers.

Section 5, Interrogatories: Address the interrogatory on whether the HMO has direct professional liability coverage, more commonly known as "malpractice" coverage. If so, provide the name of the carrier, the limits of coverage, and the expiration date of the policy.

FIS 0084 (10/02) Office of Financial & Insurance Services

Summary of Subsidiary Corporations

Complete and submit a separate summary for *each* subsidiary corporation (reproduce form if necessary). A subsidiary is any controlled, owned or affiliated entity as described in Section 500.115 of the Michigan Insurance Code of 1956 as amended. Complete on a calendar year basis unless otherwise indicated.

SUBMIT FORM AND ATTACHMENTS WITH MICHIGAN ANNUAL STATEMENT FILING.

Submission Required By:	2002
NONPROFIT HEALTH CARE CORPORATIONS DENTAL SERVICE CORPORATIONS	DUE 3/1/03

Bar Code Required - Place Bar Code Here

Name of Company (Insurer--NOT Subsidiary)		NAIC Group number	NAIC Company code
Name and address of Subsidiary		Subsidiary contact person name and title	
		Contact person phone number ( )	Subsidiary state of incorporation
Summary of business activity of Subsidiary		Subsidiary Tax I. D. Number (FEIN)	Subsidiary date of incorporation
Subsidiary--Total number of shares authorized		Describe all lawsuits or other litigation pending against Subsidiary	
Subsidiary--Par value of stock			
Number of Subsidiary shares owned by Insurer at year end 2001			
Number of Subsidiary shares owned by Insurer at year end 2002			
2002 Dividends Subsidiary paid to Insurer			
Dates dividends were paid:			

Required Attachments *(if applicable)*:

I. Attach a detailed description and supporting documentation on any of these relationships or transactions between Insurer and the Subsidiary: *(check to show attachments are included; if there were no such transactions or relationships, check to indicate none)*

1. Loans, other investments, purchases, sales of, or exchanges of securities of the Subsidiary.
   ____Attachments included ____None
2. Purchases, sales of, or exchanges of assets.
   ____Attachments included ____None
3. Transactions not in the ordinary course of business.
   ____Attachments included ____None
4. Guarantees for the benefit of a subsidiary which may result in a contingent exposure to Insurer's assets.
   ____Attachments included ____None
5. All management and service contracts and all cost sharing arrangements.
   ____Attachments included ____None

II. Attach financial statements and exhibits for the year ending December 31, 2002. List titles of the attachments below:

III. Attach a completed form FIS 0084 Summary of Subsidiary Corporations for each *Subsidiary of the Subsidiary.* List names of all the Subsidiaries of the Subsidiary below: *(indicate if none)*

____None

PA 218 of 1956 as amended, requires submission by nonprofit health care corporations and dental service corporations who were controlled, owned or were affiliated with an entity during the calendar reporting year, as described in Section 500.115 of the Michigan Insurance Code of 1956 as amended. Failure to properly complete and file this report may result in a compliance action against the corporation.

FIS 0279 (10/02) Office of Financial & Insurance Services

Quarterly Notice of Medicaid Claims Defects

HMO name

Report may be based on Medicaid Claims *OR* Medicaid Claims Lines.

Indicate the basis you are using:

choose only one

- ☐ **Medicaid Claims**
- ☐ **Medicaid Claim Lines**

Report total Medicaid claims/claim lines received in report period.	Report total number of second denied Medicaid claims/claim lines in report period.	Report second denied Medicaid claims/claim lines as a percentage of total claims processed in report period.

This report is due quarterly even if there were no defective claims to report for the quarter

Indicate which report you are filing.

- ☐ **Q1 (Jan, Feb, Mar) DUE April 30**
- ☐ **Q2 (Apr, May, Jun) DUE July 31**
- ☐ **Q3 (Jul, Aug, Sep) DUE October 31**
- ☐ **Q4 (Oct, Nov, Dec) DUE January 31**

Report Year 20____

Use the formats below to prepare the Report and Summary using your office information systems. Provide report in black print on 8 1/2" x 11" white sheets. Type must be in a style, size and spacing that is easily readable, such as Arial or Helvetica 7pt. or larger. Report can be oriented either "Landscape" or "Portrait." Number pages as Page X (page number) of Y (total pages attached).

Report Claim or Claim Line rejected a SECOND TIME. Do not report Claims/Claim Lines rejected only once!

Label columns on each page in the order shown below. Use a line for each claim or claim line with defect (rejected twice). Enter each item in this order. Use at least 3 spaces or a vertical line to separate columns. Record all dates in MM-DD-YY format.

Public Act 187 of 2000 amends the Social Welfare Act (Public Act 280 of 1939) to add requirements for timely payments to providers for covered health care services rendered to persons enrolled in Medicaid who are members of a qualified health plan (QHP). MCL 400.111i(2)(i) requires that a qualified health plan notify the health professional or facility and the commissioner of a defect in a claim if it is not payable the second time it has been submitted, regardless of the reason.

REPORT FORMAT: *Please sort report in ascending order based on Provider Federal Employer ID (FEIN)*

QHP Claim Identifier	Provider name	Provider type code	Provider's Federal Employer ID (FEIN)	Date of Service	Date claim was received	Date claim rejection notice sent to provider	Rejection code (FIRST rejection)	Date SECOND claim was received	Date SECOND claim rejection notice sent to provider	Rejection code (SECOND rejection)
S123456	Sample Clinic	XX	222222222	02-22-22	03-22-22	04-22-22	123456	05-22-22	06-22-22	654321

Each reported claim should look similar to this example

SUMMARY FORMAT: *Label columns as shown below to prepare a Summary by Rejection Code. Report can be oriented either "Landscape" or "Portrait." Number pages as Page X (page number) of Y (total pages attached). Please sort summary by "Second denied Medicaid claims as a percentage of total..." (last column) in descending order (highest percentage first, lowest percentage last)*

Rejection Code	Description of rejection code	Number of Medicaid claims denied a second time in report period	Second denied Medicaid claims as a percentage of total second denied claims for report period
MEMNEL	Member not eligible at date of service	29	4.27%

Each line should look similar to this example

When this form is complete attach report and summary.

Mail or deliver allowing adequate time for filing to arrive at OFIS on or before the quarterly due date.

Send to: **Office of Financial and Insurance Services**
Health Plans Division
P.O. Box 30220
611 W. Ottawa
Lansing MI 48909-7720

Certification:

I certify that I have thoroughly examined this report . The information contained in and attached to it is complete and correct to the best of my knowledge and belief.

Signature of authorized provider represenative | Date signed

Signer's name and title (please type or print)

Contact person name and phone number (include area code)

( )

Contact person 's EMail address

Visit OFIS on the Web at:
www.michigan.gov/ofis

Michigan Department of Consumer & Industry Services
"Serving Michigan...Serving You"

Phone OFIS toll-free at:
1-877-999-6442

Read instructions before completing form

FIS 0317 (11/02) Office of Financial & Insurance Services

Revenue and Expense Report for HMOs

Name of Company
Company NAIC Group number and Company code

Multiple copies of this form are necessary to complete yearly filing requirements. *Please retain unused original form to make copies for each filing.*

Use checkboxes to indicate which report you are filing:

- ☐ **2002 Annual data DUE March 1, 2003**
- ☐ **Q1 data DUE May 15, 2003**
- ☐ **Q2 YTD DUE August 15, 2003**
- ☐ **Q3 YTD DUE November 15, 2003**

Filing is required for: All HMOs	**2003**
	DUE quarterly

Bar Code Required - Place Bar Code Here

File this report with your quarterly statement filings.
Address questions about this form to:
Office of Financial Evaluation (517) 373-0246

page 1 of 2	1-Commercial	2-Michigan-Child	3-Title XVIII Medicare	4-Title XIX Medicaid	5-Fee for service	6-Other *	7-Total
1. Member months							
2. Net premium income							
3. Change in unearned premium reserves and reserves for rate credit							
4. Fee-for-service							
5. Risk revenue							
6. Aggregate write-ins for other health care related revenues							
7. Aggregate write-ins for other non-health revenues							
8. Total Revenues (Lines 2 to 7)							
Medical and Hospital							
9. Hospital/Medical benefits							
A) Physician services-primary care							
B) Physician services-specialty care							
C) Hospital-inpatient							
D) Hospital-outpatient							
10. Other professional services							
11. Outside referrals							
12. Emergency room and out-of-area							
13. Prescription drugs							
14. Aggregate write-ins for other medical and hospital							
15. Incentive pool and withhold adjustments							
16. Subtotal (Lines 9 to 15)							

page 2 of 2	1-Commercial	2-Michigan-Child	3-Title XVIII Medicare	4-Title XIX Medicaid	5-Fee for service	6-Other *	7-Total
Less							
17. Net reinsurance recoveries							
18. Total medical and hospital (Lines 16 minus 17)							
19. Non-health claims							
20. Claims adjustment expenses							
21. A) General administrative expenses other than marketing							
B) Marketing expenses only							
22. Increase in reserves for life and accident and health contracts							
23. Total underwriting deductions (Lines 18 to 22)							
24. Net underwriting gain or (loss) (Lines 8 minus 23)							
25. Net investment income earned							
26. Net realized capital gains or (losses)							
27. Net investment gains or (losses) (Lines 25 plus 26)							
28. Net gain or (loss) from agents' or premium balances charged off							
29. Aggregate write-ins for other income or expenses							
30. Net income or (loss) before federal income taxes (Lines 24 plus 27 through 29)							
31. Federal and foreign income taxes incurred							
32. Net income (loss) (Line 30 minus line 31)							

Details of Write-ins: *Give line number (Line 6, 7, 14 or 29) and name of item. Attach additional sheet if necessary.*

TOTAL SURPLUS OF COMPANY ►

*** Indicate Line(s) of business included in column 6-Other:**

Certification

I certify that I am an officer of the comany named in this report, and that I have authority to prepare and file this report. I have examined this report thoroughly, and it is true, complete and correct to the best of my knowledge and belief.

Signature	Date signed	Person and phone number to contact regarding this report
Signer's name and title typed or printed		

PA 218 of 1956 as amended requires submission of this form by all licensed Health Maintenance Organizations.Failure to complete and submit this form properly could result in a compliance action or revocation of your authority to do business in Michigan.

FIS 0318 (10/02) Office of Financial & Insurance Services

Complaint and Grievance Summary for Health Carriers

page 1 of 2

Complete each table in this report based on complaints/grievances that were resolved (closed) in the calendar report year.

Filing is required for: All commercial insurers, HMOs, AFDS and BCBSM

2002

DUE April 15, 2003

Name of Company	NAIC Group number and Company code	**Filing company is (select only one):** ☐ **A commercial insurer** ☐ **An HMO, AFDS or BCBSM**

Instructions for Table 1: *Do not report expedited reviews on this table.*

Provide the number of Complaints/Grievances by decision for each level. If a health carrier has more than 3 levels of review, group them with level 3. If a health carrier does not have a level of review shown in the table, enter NA (for not applicable). Compile data based on the full calendar year.

For the purpose of this report, use Adverse Determination as defined in Section 550.1903(a] and Grievance as defined in Section 500.2213(4)(b) of the Insurance Code [BCBSM is Rule R550.101(e)] .

Table 1

Grievances *NOT resulting from adverse determinations or denials* *Please enter total number held at each level*		Health Carrier position upheld	Health Carrier position overturned	Compromise resolution reached	Total Decisions made
	Level 1				
	Level 2				
	Level 3				

Grievances *resulting from adverse determinations or denials* *Please enter total number held at each level*		Health Carrier position upheld	Health Carrier position overturned	Compromise resolution reached	Total Decisions made
	Level 1				
	Level 2				
	Level 3				

How many grievances took longer than the statuatory timeframe as provided in Section 500.2213 [BCBSM is Section 550.1404(2)(a)] of the Insurance Code to make a final written determination?

For each grievance that took more than the statuatory timeframe to make a final written determination as provided in Section 500.2213(1)(k), [BCBSM is Section 550.1404(2)(a)], provide the following information: *(prepare a report that provides this data in the order given)*

1-1. Grievant's name
1-2. Date grievance was filed.
1-3. Date final decision was rendered.
1-4. Number of calendar days (excluding allowable tolled days) from date filed to render a final decision.
1-5. Summarize the reason(s) the statuatory timeframe was exceeded.

Instructions for Table 2: *Do not report expedited grievances. Do not report external reviews involving Medicaid, Medicare Supplement, or Medicare+Choice coverages.The "Grievance Terminated" column refers to external reviews terminated by the health carrier as a result of reconsideration by the health carrier.* Section 550.1923(3) of the Insurance Code, the Patient's Right to Independent Review Act (PRIRA) requires each health carrier to annually report all requests for external review.

Table 2	**External Reviews *Non-Expedited***	Health Carrier position upheld	Health Carrier position overturned	Compromise resolution reached	Grievance Terminated	Total Decisions made
	Total for reporting period					

Instructions for Table 3: *Report only the number of Expedited Internal Reviews.* Expedited grievances are defined in Section 550.2213(1)(l) [BCBSM is 550.1404(4)] of the Insurance Code

Table 3	**Internal Reviews *Expedited***	Health Carrier position upheld	Health Carrier position overturned	Compromise resolution reached	Grievance Terminated	Total Decisions made
	Total for reporting period					

Instructions for Table 4: *Do not report expedited grievances reviewed internally. Do not report external reviews involving Medicaid, Medicare Supplement, or Medicare+Choice coverages.* Section 550.1923(3) of the insurance Code, PRIRA requires each health carrier to annually report all requests for external review.

Table 4	**External Reviews *Expedited***	Health Carrier position upheld	Health Carrier position overturned	Compromise resolution reached	Total Decisions made
	Total for reporting period				

All Health Carriers:

Attach a self-generated report that summarizes and analyzes the categories, types and numbers of complaints and grievances, resulting from adverse and non-adverse determinations and external reviews addressed during the reporting year.

Certification

I certify that I am an officer of the company named in this report, and that I have authority to prepare and file this report. I have examined this report thoroughly, and it is true, complete and correct to the best of my knowledge and belief.

Signature of Officer	Date signed	Person and phone number to contact regarding this report
Signer's name and title typed or printed		
Signer phone number	Signer EMail address	Contact Person EMail address

PA 218 of 1956, PA 350 of 1983 and PA 251 of 2000, as amended requires submission of this form by all licensed health carriers. Failure to complete and submit this form properly could result in a compliance action or revocation of your authority to do business in Michigan.

Return completed report on or before April 15th to:
Office of Financial and Insurance Services
Consumer Services
PO Box 30220
Lansing MI 48909-7720

Commercial Insurers:
Address questions about this form to **Consumer Services** (517) 373-0989

HMOs, AFDS and Blue Cross Blue Shield of Michigan:
Address questions about this form to **Health Plans Division** (517) 241-2349

Read instructions before completing form

FIS 0320 (11/02) Office of Financial & Insurance Services

HMO Inpatient Discharges & Benefit Payouts Report

Multiple copies of this form are necessary to complete yearly filing requirements. Please retain unused original form to make copies for each filing.
File with your quarterly and annual statements. Provide data based on calendar year.

Filing is required for:
All HMOs

2003

DUE quarterly

Bar Code Required - Place Bar Code Here

Name of HMO

NAIC Group number and Co. code

Indicate which report you are filing.

- ☐ **2002 Annual data DUE March 1, 2003**
- ☐ **Q1 data DUE May 15, 2003**
- ☐ **Q2 YTD DUE August 15, 2003**
- ☐ **Q3 YTD DUE November 15, 2003**

Section 1-Contracted Hospitals *Attach additional sheet(s) if necessary.*

Name of contracted hospital	Total number of Inpatient Discharges		
	Elective	Emergency	Total
Subtotals:			

Address questions about this form to: Office of Financial Evaluation (517) 373-0246

continued on page 2

Section 2-NON-Contracted Hospitals *Attach additional sheet(s) if necessary.*

Name of NON-Contracted hospital	Total number of Inpatient Discharges		
	Elective	Emergency	Total
Subtotals:			

Section 3-Discharge Statistics

	Elective Inpatient Discharges from Contracted Hospitals	Elective Inpatient Discharges from NON-Contracted Hospitals	TOTAL Elective Inpatient Discharges from Contracted AND NON-Contracted Hospitals
Number of Discharges			
Percentage of Discharges	%	%	100%
Enter amount (in dollars) of 3 month projected incurred claims from non-contract hospitals			$

Section 4-Total Benefit Payouts

	Total payments to Contracted Providers	Total payments to NON-Contracted Providers	TOTAL Medical and Hospital Expenses
Total Benefit Payout			
Percentage of Payments	%	%	100%

Section 5-Interrogatories

1. Does the HMO have direct professional liability coverage (commonly known as "malpractice")? ☐ Yes ☐ No **If yes, please complete below:**

Name of carrrier	Limits of coverage	Expiration date

Certification

I certify that I am an officer of the HMO named in this report, and that I have authority to prepare and file this report. I have examined this report thoroughly, and it is true, complete and correct to the best of my knowledge and belief.

Signature	Date signed	Person and phone number to contact regarding this report
Signer's name and title typed or printed		

PA 218 of 1956 as amended requires submission of this form by all licensed Health Maintenance Organizations.Failure to complete and submit this form properly could result in a compliance action or revocation of your authority to do business in Michigan.

Read instructions before completing form

FIS 0321 (11/02) Office of Financial & Insurance Services

Working Capital Calculation

Multiple copies of this form are necessary to complete yearly filing requirements. Please retain unused original form to make copies for each filing.
File with your quarterly statements. Provide data based on calendar year.
Address questions about this form to: Office of Financial Evaluation (517) 373-0246

Filing is required for: All HMOs, AFDS and Nonprofit Dental Care Corporations

2003

DUE quarterly

Bar Code Required - Place Bar Code Here

Name of company | NAIC Group number and Co. code

Indicate which report you are filing.

- ☐ **Annual data DUE March 1, 2003**
- ☐ **Q1 data DUE May 15, 2003**
- ☐ **Q2 data DUE August 15, 2003**
- ☐ **Q3 data DUE November 15, 2003**

Instructions: The purpose of the Working Capital Calculation is to demonstrate continued compliance with Section 3555 of the Michigan Insurance Code for HMOs and AFDS, and Section 550.357 of the Michigan Insurance Code for Nonprofit Dental Care Corporations, and to permit the Office of Financial and Insurance Services (OFIS) to better analyze the company's financial condition. Working capital is defined as current assets minus current liabilities. The NAIC health blank no longer provides a classified balance sheet. This limits the ability of OFIS to accurately calculate companies' working capital from the financial statements. All HMOs, AFDS and Nonprofit Dental Care Corporations will be required to prepare and submit this report quarterly with their financial statements.
Current assets are assets with a life of one year or less. The form provides a listing of some potential current assets but an analysis of whether assets meet the current assets definition must be performed by the company. Only report assets that meet the definition of current assets on this form. **Current Assets should exclude the statutory deposit.** Current liabilities are obligations that are payable within one year or less. Only report liabilities that meet the definition of current liabilities on this form.

Current Assets

1. Cash and short-term investments _____
2. Accident and health premiums due and unpaid _____
3. Investment income due and accrued _____
4. Health care receivables _____
5. Amounts due from parent, subsidiaries and affiliates _____
6. Amounts recoverable from reinsurers _____
7. Receivable for securities _____
8. Federal income tax recoverable _____

Aggregate write-ins: *(describe each item)*

9. _____
10. _____
11. _____
12. _____

13. Total Current Assets (sum of 1 thru 12) _____

Current Liabilities

14. Claims unpaid _____
15. Accrued medical incentive pool and bonus payments _____
16. Unpaid claims adjustment expenses _____
17. Premium received in advance _____
18. General expenses due and accrued _____
19. Federal income tax payable _____
20. Borrowed money _____
21. Amounts due to parent, subsidiaries and affiliates _____
22. Payable for securities _____

Aggregate write-ins liabilities: *(describe each item)*

23. _____
24. _____
25. _____
26. _____

27. Total Current Liabilities (sum of 14 thru 26) _____

Total Working Capital (line 13 minus line 27) _____

Certification

I certify that I am an officer of the company named in this report, and that I have authority to prepare and file this report. I have examined this report thoroughly, and it is true, complete and correct to the best of my knowledge and belief.

Signature | Date signed | Person and phone number to contact regarding this report

Signer's name and title typed or printed

PA 218 of 1956 as amended requires submission of this form by all licensed Health Maintenance Organizations, AFDS and Nonprofit Dental Care Corporations. Failure to complete and submit this form properly could result in a compliance action or revocation of your authority to do business in Michigan.

FIS 0322 (9/02) Office of Financial & Insurance Services

Michigan Health Insurance Enrollment, Premiums & Losses

Name of Company | **NAIC Number**

Submission Required By:
All Property & Casualty Insurers
All Life & Health Insurers
All Health Maintenance Organizations
All HMDI, All AFDS
All Fraternal Benefit Societies

2002

DUE
3/1/03

Read instructions before completing form

Please submit this form with your 2002 Michigan Annual Statement.

		Policies in Force	Member Months	Number of Lives	Direct Premiums Written	Direct Losses Paid
Individual Business	**1** Major Medical-PPA					
	2 Major Medical-no PPA					
	3 Disability Income					
	4 Medicare Supplement					
	5 High Deductible w/MSA					
	6 Short term or 1-time limited duration					
	7 MIChild					
	8 Long Term Care-qualified					
	9 Long Term Care-non-qualified					
	10 Dental					
	11 Vision					
	12 Prescription Drug					
	13 Other: Identify					
	14 **Total Individual**					
Group Business	**15** Small Employer Major Medical (<51)-PPA panel					
	16 Small Employer Major Medical (<51)-no PPA panel					
	17 Large Employer Major Medical (>50)-PPA panel					
	18 Large Employer Major Medical (>50)-no PPA panel					
	19 Union/Taft Hartley Plan Major Medical					
	20 Association Major Medical Medical					
	21 Other Group Medical: Identify					
	22 Disability Income					
	23 Medicare Supplement					
	24 High Deductible w/MSA					
	25 StopLoss/Excess Loss					
	26 Short term or 1-time limited duration					
	27 MIChild					
	28 Long Term Care-qualified					
	29 Long Term Care-non-qualified					
	30 Dental					
	31 Vision					
	32 Prescription Drug					
	33 Medicaid					
	34 Other-*identify*					
	35 **Total Group**					
	36 **Grand Total (tie to state page)**					

Instructions for completing form FIS 0322

All insurers with accident and health authority, disability income authority, all nonprofit health care corporations, all nonprofit dental care corporations, all health maintenance organizations, and all alternative financing and delivery systems are required to submit an accurate and complete form FIS 0322. Industry analysts, policy makers and researchers use these data to understand more about Michigan's health insurance market. You must submit a form by the due date, even if your company has had no activity during the year.

The grand totals on this form must equal amounts reported as Michigan business on your annual statement, as shown below:

Property & Casualty Statement-Grand Totals to equal sum of lines 13 through 15.7 on page 24

Life & Accident & Health Statement-Grand Totals to equal line 26 on page 29

Fraternal Statement-Grand Totals to equal line 26 on page 28

Health Statement-Grand Totals to equal totals on the Exhibit of Premiums Enrollment and Utilization and totals on the Underwriting and Investment Exhibit, Part 1.

All monetary amounts must be reported in whole dollars.

Column Instructions:

Column 1-Report the number of policies and group agreements in force as of December 31 of the reporting year. This is the number of individual policies or group polices in force that cover any Michigan citizens, not the number of lives covered under those policies.

Column 2-A member month is coverage for one month for one covered person. It is a measure of exposure. Member months includes dependents as well as a named insureds or subscribers.

Column 3-Total number of Michigan lives as of December 31 of the reporting year. This number is the total of the policyholders/subscribers plus all covered dependents, including spouses.

Column 4-Direct Premium Written. This amount should include premiums for the full policy term arising from policies written during the year.

Column 5-Direct losses paid include all claims on direct business paid during the year.

Line Instructions:

Lines 1 through 5- Major Medical includes major medical, comprehensive medical and other hospital-surgical-medical benefit plans designed to be the insured's primary healthcare coverage. The term does not include short-term or 1-time limited duration coverage, accident-only, specified disease, individual hospital indemnity, credit, dental-only, visual only, prescription drug only, Medicare supplement, Medicare + Choice, long-term care, disability income insurance, MIChild, coverage issued as a supplement to liability insurance, workers compensation or similar insurance, or automobile medical-payment insurance.

Lines 6 and 26-A short term or 1-time limited duration policy is an individual health policy or certificate that does not cover pre-existing conditions and is issued to provide coverage for a period of 185 days or less, except that the health policy may permit a limited extension of benefits after the date the policy ended solely for expenses attributable to a condition for which a covered person incurred expenses during the term of the policy. It must be nonrenewable, except that the health insurer may provide coverage for 1 or more subsequent 185 day or less periods, if the total of the periods of coverage do not exceed a total of 185 days out of any 365-day period, plus any additional days permitted by the policy for a condition for which a covered person incurred expenses during the term of the policy. It must be available with an immediate effective date, without underwriting, upon receipt by the insurer of a completed application indicating eligibility under the health insurer's eligibility requirements, except that coverage that includes optional benefits may be offered on a basis that does not meet this requirement. Short term individual policies should be reported in the individual section. Short term individual certificates under a group contract issued to a trust should be reported in the group section.

Line 25-Stop Loss/Excess Loss is primary insurance coverage that reimburses an employer or other sponsor of a self-funded health benefit plan for claims beyond a specified specific and/or aggregate attachment point. It does not include a minimum premium plan, which should be reported as employer, union, or association major medical business, as applicable.

Lines 8, 9, 28 and 29-Long term care. Report as qualified all long term care policies considered to be tax qualified. Such policies are guaranteed renewable, only cover qualified long-term care services, and cover only recipients certified as "chronically ill."

Lines 1, 2, 15-18-PPA means Prudent Purchase Agreement, i.e. a policy that requires or encourages the use of a particular panel of providers for benefits under a policy or contract.

Lines 4 and 23-Medicare Supplement is defined in the NAIC annual statement instructions.

Line 5 and 24-High Deductible with MSA means a high deductible medical insurance policy designed to attach after a high deductible funded by a Medical Savings Account.

Line 20-For association business, the number of groups means the number of associations, not the number of groups within the association. The total number of lives includes all the member or employees of all the groups that make up every association covered.

Line 7 and 27-MIChild means policies issued through the MIChild program, administered by the Michigan Department of Community Health.

Address questions regarding this form to:	Return completed form with your Michigan Annual Statement filing or send to this address before the due date:
Office of Financial & Insurance Services **Office of Policy, Conduct and Consumer Assistance-Policy Division** **Toll free: (877) 999-6442** **or Lansing area: (517) 373-1866**	**Office of Financial & Insurance Services** **Policy Division** **P.O. Box 30220** **Lansing, MI 48909-7720**

CERTIFICATION I certify that I am an officer of the company named in this report and that I have authority to prepare and file this report. I have examined this report thoroughly, and it is true, complete and correct to the best of my knowledge and belief.

Signature of Company Officer	Date signed
Company Officer's name and title typed or printed	Person and phone no. to contact regarding this report:

PA 218 of 1956 as amended requires filing by all insurers, HMOs and AFDS. Failure to file properly could result in a compliance action against the company.

APPENDIX II:

SUPPLEMENTAL CHECKLIST ON WHERE TO FILE CERTAIN DOCUMENTS WITHIN OFIS

WHERE TO DIRECT FILINGS WITHIN OFIS

Document	Division/Person	Number of Copies
Financial Statements	Office of Financial Evaluation	1
Audited Financial Statements	Office of Financial Evaluation	1
NAIC Supplemental Compensation Exhibit	Office of Financial Evaluation	1
Management Discussion & Analysis	Office of Financial Evaluation	1
Statement of Actuarial Opinion	Office of Financial Evaluation	1
Revenue and Expense Report for HMOs (FIS 0317)	Office of Financial Evaluation	1
HMO Inpatient Discharges & Benefit Payouts Report (FIS 0320)	Office of Financial Evaluation	1
Working Capital Calculation (FIS 0321)	Office of Financial Evaluation	1
Michigan Health Insurance Enrollment, Premiums and Losses (FIS 0322)	Office of Policy, Conduct & Consumer Assistance - Policy Division	1
Changes to Articles of Incorporation and Bylaws	Office of Financial Evaluation – Enterprise Monitoring and Insurance Examinations Division, Sue Houseman	1
Changes to Certificate of Authority	Office of Financial Evaluation – Enterprise Monitoring and Insurance Examinations Division, Sue Houseman	1
Officer and Director Disclosure Statements	Office of Financial Evaluation, Financial Analyst	1
Form B and C Holding Company Statements	Office of Financial Evaluation, Financial Analyst	1
Form D Holding Company Filing	Office of Financial Evaluation, Financial Analyst	1
Dividend Payment Requests	Office of Financial Evaluation, Financial Analyst	1
Form A, Change of Control	Office of Financial Evaluation – Enterprise Monitoring and Insurance Examinations Division, Sue Houseman	1
Request for Approval on Transfer of Membership	Office of Financial Evaluation, Financial Analyst	1
Changes in Service Area	Office of Policy, Conduct & Consumer Assistance - Health Plans Division, Regulatory Analyst	1
Provider Agreements	Office of Policy, Conduct & Consumer Assistance - Health Plans Division, Regulatory	1

	Analyst	
Rates	Office of Policy, Conduct & Consumer Assistance - Health Plans Division, Karen Dennis	1
Certificates of Coverage and Riders, Provider Directory and Member Handbook	Office of Policy, Conduct & Consumer Assistance - Health Plans Division, Regulatory Analyst	1
Quarterly Notice of Medicaid Claims Defects (FIS 0279)	Office of Policy, Conduct & Consumer Assistance - Health Plans Division	1
Complaint and Grievance Summary for Health Carriers (FIS 0318)	Office of Policy, Conduct & Consumer Assistance – Consumer Services Division	1